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TO: Honorable Task Force Members
Virginia Health Reform Initiative (VHRI)

FROM: Jill A. Hanken, Staff Attorney

RE: Health Reform Initiative – Key Issues / Concerns

Introduction

The Affordable Care Act (ACA) will dramatically expand health coverage in Virginia as a result of the new premium tax credits and a robust Medicaid expansion. These changes will significantly reduce Virginia's uninsured population and improve access to health care for hundreds of thousands of Virginians. My primary interest is to ensure that all consumers – particularly low income and uninsured Virginians – can easily access health insurance through a single point of entry. Beyond enrollment, patients must receive high quality care, and providers must have an assurance of reasonable and prompt payments.

This is truly an opportunity to rethink the overall delivery of health care in the Commonwealth. At the same time, ACA challenges us to implement the required changes in a careful and systematic way. I applaud Governor McDonnell and Secretary Hazel for establishing this Health Reform Initiative and its Task Forces. It is absolutely necessary to start now to effectuate ACA provisions that have already taken effect and to prepare for the significant changes which take effect in 2014.

While the federal government will pay for the bulk of the costs of the Medicaid expansion and the entire cost of exchange subsidies, we also have to start now to determine how Virginia will pay for its responsibilities under ACA. I believe the Advisory Committee should tackle that subject as a part of its deliberations. I would recommend that a distinct subcommittee be set up for that sole purpose. This subcommittee should review options for new revenue and also measure cost savings from ACA (i.e. Could Virginia achieve savings on public employee health costs by participating in the federal reinsurance subsidies for early retirees? Can significant General Fund savings be achieved by substituting federal Medicaid dollars for current state and local spending on adults' indigent care, mental health services, social services, and other state-funded programs that, for the first time, will potentially fit under Medicaid's umbrella? See http://www.rwjf.org/files/research/66488.pdf)

I have the following comments for the six VHRI task forces. Because all the issue areas are truly inter-related, I am providing each committee with all my comments.

Insurance Reform Task Force & Purchaser's Task Force

Private Insurance

Beginning in 2011, ACA requires health plans to meet new Medical Loss Ratios, and it requires states to review premium increases and provide the public with information about such increases.

These are two of the most critical aspects of reform in Virginia, since health insurers have operated over the years in this state with relatively little oversight. [BOI must approve rates only for the individual market, but that product only requires a "minimum loss ratio" of 60%. HMOs and small group insurance must file reports of increases, but there is no approval required. Non-HMO Group plans that raise rates do not have filing requirements.]

Other ACA insurance reforms, such as prohibiting pre-existing conditions for children, ending lifetime limits, ending co-pays on preventive services, phasing out annual limits on certain services, and extending coverage to young adults have been effective since September 23, 2010.

Yet, we have an enormous problem since our Bureau of Insurance (BOI) has no real enforcement authority to require Virginia companies to comply with all these federal requirements.

In August NAIC Conducted 50-state survey in August to determine which states had ability to enforce PPACA provisions. See http://www.naic.org/documents/index_health_reform_section_ppaca_state_enforcement_authority.pdf

Unlike most other states, Virginia's response to this survey stated it had:

- No enforcement authority
- No sufficient resources to substantially enforce immediate implementation provisions
- No sufficient legal authority to conduct policy form reforms
- No sufficient legal authority to investigate complaints
- No sufficient legal authority to conduct market conduct exams regarding failure to comply

Recommendations:

Develop legislation giving BOI broad authority to enforce PPACA provisions, including the authority to impose fines/penalties for non compliance.

Develop a comprehensive rate review process that includes public input and

transparency. [BOI received a $1 million grant from HHS to improve oversight of health insurance premium increases. This should allow for development of a rigorous rate review system with transparency for consumers. I'm disappointed that the BOI's proposed grant activities include no plans to make more information available to the public. Compare all states' proposals at www.healthcare.gov/news/factsheets/rateschart.html]

Virginia should aggressively seek funding for and establish a "Consumer Assistance" program to help people navigate the new systems. The program should use community-based organizations to provide one-on-one counseling and advocacy.

The Insurance exchange

The Insurance exchange will be the gateway for Virginians to access health insurance and possibly other public benefits and services.

ACA contains very explicit provisions that require enrollment systems to be:

Consumer-friendly: ACA requires states to create enrollment systems that ensure that applicants are screened for all available health subsidy programs and enrolled in the appropriate program, with minimal collection of information and documentation from applicants.

Coordinated: ACA requires states to coordinate efforts across available health subsidy programs to enable seamless transitions between those programs.

Simplified: ACA requires states to operate a streamlined enrollment process and foster administrative simplification, using uniform income rules and forms as well as paperless verification procedures.

Technology-enabled: ACA requires states to operate enrollment Web portals and securely exchange and utilize data to support the eligibility determination. In addition, ACA directs the Secretary of Health and Human Services to establish standards and protocols for electronic enrollment and eligibility systems, to allow for significantly improved streamlining and cross-agency capabilities.

See these statutory provisions in http://www.kff.org/healthreform/upload/8090.pdf .

Recommendations Regarding Structure:

I believe the exchange in Virginia should be a new, independent entity. BOI, DMAS, DSS, DOH will be critical partners; but none seems ideally suited to house the exchange. An independent entity can start fresh, with credibility that will appeal to all customers.

The exchange must be structured to avoid adverse selection. See

http://www.cbpp.org/cms/index.cfm?fa=view&id=3267

Require exchange products to offer "value-based insurance design" incentives to utilize high value, evidence-based treatments and diagnostic tests through cost-sharing linked to value and efficiency. Experts estimate that VBID offerings could reduce health care inflation by up to one third

Recommendations Regarding Applications and Enrollment:

Design the entire application and enrollment process with the consumer in mind – especially low-income individuals who may have special needs.

Offer "One-stop-shopping" for health insurance (including Medicaid/FAMIS) and other benefits.

Use a single application – reduced paperwork, electronic matches, information sharing. Current systems must be upgraded to meet the data matching requirements which will likely require additional funding. Furthermore, the new eligibility rules and the interactions between Medicaid/CHIP and the exchange will require significant training and education of State agency staff as well as community organizations that interact with low- and moderate-income individuals

Streamline, simplify, improve current Medicaid to ease the transition to the Exchange and more easily determine who is "newly eligible" – e.g. revise/simplify income and resource rules for non-elderly populations.

Coordinate application and recertification rules and procedures in all the programs.

Expect low income enrollees to move in and out of the Exchange and Medicaid eligibility. Transitions should be seamless, and benefits should be uniform. Consider 12-month coverage for all individuals to minimize shifts based on changes in circumstances.

Examine all systems currently in use to store data and manage programs. Data systems must be able to "talk" to each other

Consider the needs of populations that may not have strong computer literacy skills or easy access to the internet. Many of the newly eligible will be very poor; many will have disabilities – physical and mental. They will need one-on one, and face-to-face application assistance for enrollment. (See Medicaid Section and Consumer Assistance Recommendation)

Carefully adhere to requirements of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. State agencies must provide equal access to their programs for people with disabilities – this includes websites and online applications. See *Modernizing Public Benefits Programs*:*What the Law Says*

State Agencies Must Do to Serve People with Disabilities
http://www.nclej.org/documents/ModernizingPublicBenefits_20Jul10.pdf

Provide required language access for individuals with limited English proficiency (LEP). The State should ensure that its computer systems for Medicaid, FAMIS and the Exchange generate notices and other vital documents to LEP individuals in their native languages.

Use ACA funding for new health care "Navigators" that could help to maximize the number of newly eligible individuals and families that ultimately enroll. Under this provision, community organizations, designated as navigators, can ensure vulnerable and underserved populations are educated about the wide array of options that will be available.

Develop a marketing plan with resources to reach hard-to-serve populations. The legislation specifically requires outreach to children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance related disorders, and individuals with HIV/AIDS.

Grants received: HHS awarded Virginia a $1,040,902 PPACA grant to help seniors and disabled people understand their Medicare and Medicaid benefits, navigate options for long-term care, and transition home from nursing or rehabilitation facilities.

Other Resources on Exchanges:

Center for Children and Families' Health Insurance Exchanges: New Coverage Options for Children and Families; http://ccf.georgetown.edu/index/health-insurance-exchanges

Community Catalyst's Considerations for Implementing an Exchange;
http://www.communitycatalyst.org/doc_store/publications/IC_Exchange_PPT.pdf

Families USA's Implementing Exchanges: A Guide to State Activities and Choices;
http://www.familiesusa.org/assets/pdfs/health-reform/Guide-to-Exchanges.pdf

Medicaid Task Force

Because of Virginia's extremely low eligibility levels for parents and lack of public coverage for childless adults (unless pregnant, disabled or elderly), DMAS has estimated a very large population of Virginians who will become "newly eligible" for Medicaid in 2014. (anywhere from 275,000 to 450,000 new Medicaid enrollees).

The federal government will pay 100% of the costs for the newly eligible for 3 years, with FFP staying at a very favorable 90% match after 2020.

All of the newly eligible will have income under 133% FPL (In 2010 - $14,404 individual, $29,327 family of four), and some will be extremely poor. Many will have medical problems, including chronic conditions that have not been treated for years.

Recommendations:

Initiate early preparation for and/or prescreening for newly eligibles, so coverage can begin in Jan. 2014. DSS and DMAS already know about the parents of Medicaid eligible children. Enrollment of this population should be fairly simple. For other newly eligible populations, outreach, education, and direct assistance will be needed.

Use the same Medicaid benefit package for the newly eligible. Virginia's current Medicaid benefit package is fairly basic with few optional services. While ACA allows a different "benchmark" package for newly eligible, it is extremely important to maintain consistency within Medicaid and the Exchange plans in order to ease inevitable transitions. Since changes in income, health status, and other factors are common, coordination and consistency of coverage between groups and over time must be key aims. Many ACA requirements, such as coverage of essential benefits and requirements for the medically frail, also support the use of the regular Medicaid benefit package for the newly eligible.

Use delivery systems that are coordinated or even overlapping with those used in Exchange plans while ensuring, at the same time, that beneficiaries retain access to vital, Medicaid-specific services, such as transportation and, in some cases, more extensive help with chronic conditions, serious health issues, and care coordination. http://www.kff.org/healthreform/upload/8092.pdf

Adopt all preventive health services for eligible adults in Medicaid by including all recommended preventive services and vaccines, to receive a 1% increase in FMAP payments for these services.

Provide more care coordination for Medicaid recipients, but not necessarily more capitated managed care. E.g. Primary Care Case Management (PCCM), Health Homes, Accountable care organizations. (See Service Delivery Section)

Consider options for a "Basic Health Program" for non-elderly adults between 133% and 200% FPL. Exchange products may not be affordable to this population. FAMIS eligible children and their parents could be enrolled together.

Fully explore ACA's new Long Term Care Options that expand Medicaid Home and Community Based Care (HCBC). This is needed to reduce the high expenditures (70%) currently spent on elderly and disabled individuals (30% of enrollees). There are numerous provisions (Money Follows the Person, Community First Choice Option, State Balancing Incentive Program, and expanding covered services for waiver participants.) These options deserve the attention of a special subcommittee.

Adopt certain Medicaid reforms before 2014

Adopt eligibility options for Legal Immigrants (Medicaid/FAMIS pregnant women, FAMIS eligible children, and Medicaid-eligible qualified immigrants). This is a very important issue, because Virginia currently limits coverage for legal immigrants in ways that are stricter than most other states. We are not taking advantage of available federal funding for this population, and the individuals' health suffers – costing more in the long run. If this gap in our Medicaid program is not closed, this population will remain uninsured even after 2014 because exchange products will still be too expensive. As a consequence, Virginia will unnecessarily continue to spend precious state-only dollars for this population.

Medicaid/FAMIS should reimburse providers for language/interpreter services. CHIPRA already increased the federal administrative matching rate for translation and interpretation services to children to 75% for Medicaid and about 70% for CHIP. The State should take advantage of this additional federal funding to provide meaningful access to LEP individuals in preparation for full implementation of the Medicaid provisions in 2014.

Extend Medicaid coverage to older foster care children who have "aged out" of the foster care system but are under the age of 26. This will be required in 2014, but it is important now.

Increase income eligibility for FAMIS children. Current eligibility is set at 200% FPL (gross income). This level is lower than 42 other states. Virginia's eligibility has not increased since the inception of the program over 10 years ago, and we are not using available federal funding.

Adopt CHIP option for State employees who would pay over 5% of their income for state insurance coverage. The state could receive some federal matching funds for this group.

Use Presumptive Eligibility (PE) to enroll uninsured individuals who present at health care providers. It allows providers to be paid for services rendered, even though applications for public coverage have not been fully processed. This is a way to effectively reach the Medicaid eligible population at the point of service. [While ACA allows hospitals to proceed with PE without state approval, the success of this new option will still depend on the State's involvement and cooperation in assisting hospitals with implementation.]

Capacity Task Force

Workforce shortages have been well documented over many years, and there are legitimate concerns about how the newly insured will access their care.

Through ACA grant opportunities, Virginia has already received nearly $30 million in funding for Community Health Centers and close to $20 million to state agencies, colleges and universities to improve and expand primary care services, especially in rural and underserved areas.

Recommendations:

To the fullest extent possible, activities related to the above grants and funding should be monitored by VHRI and Secretary Hazel to ensure coordination.

Provide substantial funding and enhance all state loan repayment programs (medical & dental – doctors and auxiliary) to focus on service in underserved areas.

Develop other incentives to keep graduates in Virginia. (e.g. commitments upon admission to training programs, tuition rebates)

Maximize enrollment in graduate nursing programs (see http://www.aacn.nche.edu/IDS/pdf/vacancy10.pdf)

Revise scope of practice restrictions (physician assistants, nurse practitioners, hygienists, etc.) E.g. Virginia law requires on-site physician supervision of nurse practitioners. In 37 states, Nurse Practitioners are authorized to practice independently or in collaborative partnerships with physicians.

Continue development of Telemedicine services

Maintain state support for safety net providers who must be available to those not covered by ACA

Resources: The Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health.* The report outlines eight recommendations calling for significant improvements at the national, state and local levels on the topics of nursing education, scope of practice, and leadership.
http://www.rwjf.org/humancapital/product.jsp?id=69909&cid=XEM_2135962

Grant Opportunity: The Health Resources and Services Administration (HRSA) will accept applications through December 1 for up to $100 million in grants (funded by PPACA) to construct and renovate school-based health centers. Hospitals are eligible to apply as a sponsoring facility. HRSA expects to award about 200 grants of up to $500,000 each in fiscal year 2011. "Healthy children are more productive children," said HRSA Administrator Mary Wakefield. "These grants will improve access to care for children, and help maximize their potential to learn."
www.hrsa.gov/grants/apply/assistance/sbhcc/

Technology Task Force

I hope the Technology Task Force will expand its purview beyond electronic health records. Technology issues and questions must also be evaluated for Virginia's Insurance Exchange to support "One-stop Shopping" and "No Wrong Door" for applications and enrollment into health insurance and possibly other benefits.

Virginia's exchange must be designed to ensure that various data bases can be effectively used to establish eligibility. Coordinating coverage between the exchange and public programs and ensuring proper transitions between the two systems will be critical, but challenging.

Some states that appear to use a single online application for several programs are Arizona, California, Maryland and Indiana. Utah is known for its effective use of multiple state data bases for eligibility determinations.

Service Delivery & Payment ReformTask Force

ACA presents an important opportunity to develop alternative care models for service delivery.

Recommendations. VHRI should thoroughly review and consider the following:

Primary Care Case Management: As an alternative to capitated HMOs, North Carolina has operated a very successful and cost-effective statewide PCCM program for its Medicaid population for several years. There is also a statewide PCCM experiment in Oklahoma running since 2004. Both have saved substantial taxpayer funds while improving the quality of care, including care for individuals with chronic diseases. http://www.ama-assn.org/amednews/2010/08/02/gvsa0802.htm

Health Homes: In January 1, 2011, states will have the option to coordinate care through "health homes." to pay for care provided by a "designated provider," "a team of health professionals," or a "health team" for eligible individuals with chronic conditions. The State will receive a 90 percent FMAP rate for the first two years. These types of programs show tremendous promise for coordinating care, particularly for Virginia Medicaid recipients with disabilities or chronic conditions. The additional federal matching funds provided by ACA make the option extremely attractive to our state. [Resources on Medical Homes: Report of the American Hospital Association: http://www.hret.org/patientcentered/resources/patient-centered-medical-home.pdf; A new policy brief from *Health Affairs* and the Robert Wood Johnson Foundation http://www.rwjf.org/coverage/product.jsp?id=68929&cid=XEM_910232]

Demonstration projects under ACA are available to

Integrate care for Medicaid beneficiaries around a hospitalization (under which payments are bundled for care that includes the hospitalization and concurrent physician services provided during the hospitalization)

Provide Medicaid global payments for eligible safety net hospital systems or networks

Develop “Accountable Care Organizations” that allow doctors receiving payments under Medicaid and CHIP to share in cost savings

Establish Medicaid Psychiatric Projects to address mental health needs of Medicaid beneficiaries

Target dual eligibles for care coordination and health quality